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Revised United States Standard Certificate of Death

(Approved by U. S. Consus and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer or Planter, Physician, Compositor, Architect. Locomotive Engineer, Civil Engineer, Stationary Fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry. and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton mill: (a) Salesman, (b) Grocery: (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as Day laborer, Farm laborer. Laborer-Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife. Housework or At home. and children, not gainfully employed, as At school or At home. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as Servant, Cook, Housemaid, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: Farmer (retired, 6 yrs.) For persons who have no occupation whatever, write None,

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid feeer (never report

"Typhoid pneumonia"); Lobar pneumonia; Bronchonneumonia ("Pneumonia." unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); Measles: Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia." "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy." "Exhaustion," "Heart failure," "Hemorrhage." "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS State MEANS OF INJURY and qualify AS ACCIDENTAL, SUICIDAL, OF HOMICIDAL, OF AS probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train-accident; Revolver wound of headhomicide; Poisoned by carbolic acid-probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Note.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, celluiitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phiebitis, pyemia, septicemia, tetanus," But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a interdate.

	STANDARD CERTII	FICATE OF DEATH BURN	TMENT OF COMMERCE
:	County Firstas 5700	State MISSOURI. Reg	ristored No
	Township Pice tas 5700	r Village	
	CityNo	n occurred in a hospital or institution, give its NAME instead	of street and number)
2	FULL NAME X		
	(a) Residence. No	St., Ward	
_	(a) Residence. No	ds. How long in U. S., if of foreign birth?	ty or town and State)
	PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DE	
3	SEX 4 COLOR OR RACE 5 SINGLE, MARRIED, WIDOWED,	16 DATE OF DEATH (month, day, and year)	1 / 7 192
	De de Divorces (arte tile word)	HEREBY CERTIFY, That I att	
	If married, widowed, or divorced	PHEREBY CERTIFY, Inati att	ended deceased from
-	If married, widowed, or divorced HUSBAND of (or) WIFE of	, 19, to	19
		that I last saw h alive on	, 19
	DATE OF BIRTH (month, day, and year)	and that death occurred, on the date stated abo	ve, atm
71	AGE Years Months Days 1(LESS than 12 day) hrs.	The CAUSE OF DEATH* was as follows:	
8 (OCCUPATION OF DECEASED		
, - ,	(a) Trade, profession, or particular kind of work		•
	particular kind of work		
	(b) General nature of industry, business, or establishment in	(duration) yrs	
	which employed (or employer) (c) Name of employer	CONTRIBUTORY	
	(c) Name of employer	18 Where was disease contracted	mos ds
91	BIRTHPLACE (city or town)	If not at place of death?	
	(State or country)	Did an operation precede death? Date of	
	10 NAME OF FATHER		
	2)	Was there an autopsy?	
13	11 BIRTHPLACE OF FATHER (CARPOT town)		
RENT	(State or country)	(Signed)	
PAR	12 MAIDEN NAME OF MOTHER	, 19 (Address)	
	13 BIRTHPLACE OF MOTHER (city or town)(State or country)	*State the Disease Causing Drath, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicual. (See reverse side for additional space.)	
14		19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	Informant(Address)	·	19
15		20 UNDERTAKER	ADDRESS
13	Filed 3-9, 1923 M. C. Walton REGISTRARS		
X	1-8184 HEGISTRARS	<u></u>	<u>.</u>

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Additional space for further statements

BY PHYSICIAN.

